Authorization for Use or Disclosure of Health Information

FORM IHS–810

QUICK REFERENCE CARD

FORM IHS–810

This card is designed to be used by staff members to guide patients through the process of authorizing the use or disclosure of their health information in compliance with HIPAA regulations. If you would like additional information or have any questions, please contact your Health Information Management (Health Records) Department. Refer patients requesting an authorization for use or disclosure of their Protected Health Information (PHI) to the Health Information Management (Health Records) Department. Patient must complete this form in black ink; red ink or felt tip pens are not allowed.

HIPAA
Health Insurance Portability and Accountability Act
PRIVACY RULE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date, and sign

I. I, John Q. Public, hereby voluntarily authorize the disclosure of information from my record. (Name of Patient)

II. The information is to be disclosed by:
Name of Facility: _____ Facility from which the information is being requested
Address: _____
City/State: _____
And is to be provided to: Facility to which information is being sent
Name of Person/Organization/Facility: _____
Address: _____
City/State: _____

III. The purpose or need for this disclosure is: Patient is not required to complete this line of information. If a patient does not complete, IHS will provide the information requested. Staff should not ask for the purpose, but may suggest "personal reasons".
Personal Reasons

IV. The information to be disclosed from my health record: (check appropriate box(es))
- ❑ Entire Record
- ❑ Only information related to (specify): _____ Checking the "entire record" does not include psychotherapy notes or sensitive information.
- ❑ Only the period of events from: _____
- ❑ Other (specify): _____
- ❑ **Psychotherapy Notes ONLY (by checking this bo** This information will not be released unless checked. This request must not be used with other releases or uses.

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.
- ❑ Alcohol/Drug Abuse Treatment/Referral
- ❑ HIV/AIDS-related Treatment
- ❑ Sexually Transmitted Diseases
- ❑ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, if this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date (if different from the date below).

I understand that IHS will not condition treatment or eligibility for care on n
care is: (1) research related or (2) provided solely for the purpose of creating I
a third party.

Request is active for one year after the date of request and only applies to records up to the date of request unless an individual sets an earlier date of expiration.

I understand that information disclosed by this authorization may be subject
longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient: John Q. Public — Patient must sign and date. April 15, 2003
Date

_____
Signature of Authorized Representative (state relationship to patient) or Witness (if signature is by thumb print or mark)
Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME (Last, First MI)	RECORD NUMBER
Use imprinting device or print legibly.	ADDRESS	
	CITY/STATE	DATE OF BIRTH

IHS-810 (09/02)

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Policy: Form IHS-810 must be completed and signed (with an original signature) prior to disclosing health information for any purpose other than treatment, payment, or healthcare operations.

Staff should not verbally agree to the authorization for the use or disclosure of any information.

Only authorizations with original signatures will be processed.

Frequently Asked Questions

Q: What should I tell a patient if they ask me what to write as an answer to "The purpose or need for this disclosure is"?

A: You may tell them to write "personal reasons" or "N/A" in the space. IHS staff is not allowed to ask what the reason for the disclosure is.

Q: What if the patient does not fill in an answer or writes N/A to "The purpose or need for this disclosure is"?

A: If a patient does not complete this line of information, it will not result in a refusal by IHS to provide the information requested.

Q: If a patient checks the box next to "Entire Record", will this include their psychotherapy notes?

A: No. The patient can check the box next to "Psychotherapy Notes", however, these notes are the property of the individual therapist or mental health professional who treated the patient. If the patient would like access to the notes, they can speak directly with their therapist or mental health professional.

Q: May a patient request an authorization of use or disclosure in writing?

A: Yes. A written request must identify the individual and description of the information desired such as date of visit or diagnosis/condition. The request must contain the name and address of the requester, date of birth, signature and date. The patient may receive in response a request for more information or a copy of the Form to complete.

Q: What if someone other than the individual patient is requesting the information?

A: If the authorization is signed by a personal representative of the individual, a staff member must document the relationship of the person who is authorized to act for the individual and file it in the patient's record.

For additional training and more information see the HIPAA Training Coordinator at your site or facility. Additional forms, policies, procedures, training, and copies of the HIPAA Quick Reference cards are available online at **www.ihs.gov**.

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